EXHIBIT C

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHER DIVISION

KOHCHISE JACKSON,

Plaintiff, Case No.: 2:19-cv-13382

-v- Hon. Terrence G. Berg

CORIZON HEALTH, INC., et al.,

Defendant.
_____/

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The Zoom recorded deposition of
ERINA KANSAKAR, M.D.,
Seattle, Washington,
Commencing at 1:05 p.m.,
Friday, March 5, 2021,
Before Cheryl McDowell, CSR-2662.

APPEARANCES:

MR. LAURENCE H. MARGOLIS - P69635
MR. IAN CROSS - P83367
Laurence H. Margolis PC
214 South Main Street, Suite 200
Ann Arbor, Michigan 48104
(734) 994-9590
larry@lawinannarbor.com
ian@lawinannarbor.com
Appearing remotely on behalf of the Plaintiff.

MR. DANIEL R. CORBET - P37306
MR. KENNETH A. WILLIS - P55045
Corbet Shaw Essad & Bonasso
30500 Van Dyke Avenue, Suite 500
Warren, Michigan 48093
(313) 964-6300
daniel.corbet@cseb-law.com
kenneth.willis@cseb-law.com
Appearing remotely on behalf of the Defendants Prime Healthcare Services and Colleen Spencer.

APPEARANCES, CONTINUED:

MR. DEVLIN K. SCARBER - P64532
Chapman Law Group
1441 West Long Lake Road
Troy, Michigan 48098
(248) 644-6326
dscarber@chapmanlawgroup.com
Appearing remotely on behalf of the Defendant Corizon Health, Inc., and Keith Papendick, M.D.

MR. MARC OSWALD - P74204
Fletcher Fealko Shoudy & Francis PC
1411 Third Street, Suite F
Port Huron, Michigan 48060
(810) 987-8444
oswald@fletcherfealko.com
Appearing remotely on behalf of the Witness.

ALSO PRESENT: MR. NEAL ROGERS, VIDEOGRAPHER

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EXHIBITS

(Exhibits premarked and retained by Counsel.)

Seattle, Washington
Friday, March 5, 2021
About 1:05 p.m.

- - -

(Plaintiff's Exhibits Nos. 1 and 4 and Defendants' Exhibits Nos. 1, 2, and 3 premarked and retained by Counsel.)

THE VIDEOGRAPHER: We are on the record. This is the video recorded deposition of Doctor Erina Kansakar being taken remotely via Zoom. Today is March 5th, 2021, and the time is 1:05 p.m. Eastern Time.

Would the attorneys please identify themselves and the court reporter please swear in the witness.

MR. CROSS: Ian Cross for the plaintiff, Kohchise Jackson.

MR. CORBET: Hi. This is Dan Corbet and Ken Willis, and we're on behalf of Prime Healthcare and Colleen Spencer.

MR. OSWALD: Mark Oswald of behalf of Doctor Erina Kansakar.

MR. SCARBER: Good afternoon. Devlin Scarber appearing on behalf of the Corizon defendants as well as Doctor Papendick.

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ERINA KANSAKAR, M.D.,

having first been duly remotely sworn, was examined and testified on her oath as follows:

EXAMINATION BY MR. CROSS:

Q. Good morning, Doctor Kansakar. My name is Ian Cross. I represent the plaintiff, Kohchise Jackson.

Have you ever had your deposition taken before?

A. Yes.

Q. So you know that we need verbal responses, no head nods, yes or no?

A. Correct.

Q. And I just want to let you know if you don't understand any of my questions, that's fine. You can ask me to clarify.

Also, this isn't an endurance test, so if you need a break, if you want to go to the bathroom, just let me know, okay?

A. Okay.

Q. So did you take the opportunity to review any records --

A. Yes.

Q. -- to prepare for this deposition?

A. Yes. I got a copy of the medical records, and I did

get a chance to review those records.

THE COURT REPORTER: Doctor, can you speak up a little bit? You're soft spoken and it's a little difficult.

Okay. Thank you.

THE WITNESS: Yes, I did get a copy of all the medical records, and I did get a chance to review those medical records.

BY MR. CROSS:

Q. Okay.

MR. SCARBER: I don't want to interrupt. Just is there any way we can get more light in the room where the doctor is?

THE WITNESS: Yeah. I'm at my home office and --

MR. SCARBER: I see.

THE WITNESS: Let me see if I can open this curtain to get some more light.

MR. SCARBER: Okay. I couldn't really see you. I can definitely hear you, so if that's the case, that's fine.

Oh, that's better actually. Thank you.

BY MR. CROSS:

Q. Okay. So let's start with a little background, Doctor Kansakar. Can you give us an overview of your

training and education since high school?

A. Sure. I did my medical school at B.P. Koirala Institute of Health Sciences in Dharan, Nepal.

I came to the United States for my general surgical residency. That was from 2006 to 2012.

After completing my general surgical residency, I did a fellowship in minimally invasive surgery at Detroit Medical Center from 2012 to 2013.

Q. What is a residency?

A. Residency is training in a medical specialty in order to be able to practice that specialty.

Q. And if I heard you correctly, your medical speciality is general surgery?

A. Correct.

Q. Are you currently practicing as a general surgeon?

A. Yes, I am.

Q. How many years have you practiced general surgery?

A. I've been in practice since August of 2013.

Q. Continuously?

A. Yes.

Q. Are you board certified?

A. Yes, I am a board certified general surgeon.

Q. Where did you work after your fellowship?

A. After completion of my fellowship, I was at Port Huron with Physician Healthcare Network.

Q. And how long did you work there?

A. I worked there until February of 2018.

Q. While you were working in Port Huron, did you treat an individual by the name of Kohchise Jackson?

A. Yes, I did.

Q. Do you recall what treatment, what condition you provided Mr. Jackson treatment for?

A. I remember Mr. Jackson, but I do not recall all the details.

After reviewing the medical records, I treated him for a complicated sigmoid diverticulitis.

Q. All right. I'm going to show you a document. I'm going to try to share the screen here.

A. Sure.

Q. And I want you to look over the document.

Can you see it?

A. Yes.

Q. All right. And let me know when you're done reviewing it and if you need me to scroll.

And this has been marked as Plaintiff's Exhibit 1.

A. I'm okay with that.

Q. Okay. Do you recognize this document?

A. Yes.

Q. What is it?

A. This is a procedure report. I did a colonoscopy for Mr. Jackson.
Q. And I see down here in this findings section, you indicated he has a colovesical fistula, is that correct?
A. Correct.
Q. What is a colovesical fistula?
A. So a colovesical fistula is a condition where there is abnormal communication between the colon and the urinary bladder.
Q. What's a colon?
A. Colon is a part of the GI tract which is it was the end of the gastrointestinal tract where the stool is being formed and kind of sits there before somebody kind of has a bowel movement.
Q. Okay. And I see above those findings in this recommendation section, you recommended an open sigmoid colectomy, is that correct?
A. Correct.
Q. What is an open sigmoid colectomy?
A. So the open sigmoid colectomy is a surgery where we make an incision right in the middle to identify the colon, usually the sigmoid colon which has a communication with the bladder in this case, to resect that portion of the colon, and that would be a sigmoid

colectomy.
Q. When you say communication with the bladder, what do you mean by that?
A. That's an abnormal connection. Sigmoid colon, sigmoid diverticulitis which this patient has is a condition where the colon has these weak pouches or protrusions through -- which are, like, weak points, and that can get infected, as a result of which they can establish abscesses or pus pockets, or it could be complicated and have communication with the adjacent organs like the urinary bladder.
So when there is an abnormal connection between the colon and the urinary bladder, it's called a fistula.
Q. All right. Now, in the recommendations section, you said: With primary anastomosis.
Am I pronouncing that correctly?
A. Correct.
Q. Possible ostomy.
What is primary anastomosis?
A. So primary anastomosis is doing a one-stage surgery where the plan is to hook the patient back to establish the natural route at the same time.
Q. So if I'm understanding you correctly, with primary anastomosis, you would do one surgery where you resect

the infected section of colon and connect the two ends together?
A. Correct.
Q. Okay. What is an ostomy?
A. So ostomy is a procedure where we do not hook the patient's two ends of the colon together but bring a bag through the abdominal wall so that the bowel -- excuse me -- the stool is rerouted into the bag, and basically patient is having bowel movements into a bag. It's a diversion.
Q. Why would you do a diversion like that, an ostomy, rather than a primary anastomosis?
A. It depends upon the condition during the surgery, if there is a lot of swelling or it would be called edema, a lot of scar tissue.
There is a concern that putting the two ends together would result in a potential leak. Then it would be safer to do an ostomy or a diversion.
Q. Okay. And for Mr. Jackson, did you perform a primary anastomosis?
A. No, I did not perform a primary anastomosis.
Q. Did you create an ostomy?
A. Yes, I did.
Q. Was that the first time you created an ostomy in your career?

A. No.
Q. About how many times have you created an ostomy?
A. I would be -- it would be very hard for me to kind of give a number, but I would say definitely close to a hundred or more.
Q. A hundred or more times.
Have you ever --
MR. SCARBER: Just objection to the timeframe. It hasn't been specified.
BY MR. CROSS:
Q. Have you ever reversed an ostomy?
A. Yes, I have.
Q. Do you know approximately how many times you performed that procedure?
A. I do not recall a number just on top of my head. I'm not able to give an exact number.
Q. But more than once I assume?
A. Absolutely more than once. More than, again, maybe closer to a hundred or more.
Q. Okay. So after you created an ostomy for Mr. Jackson, did you prescribe a plan of treatment?
A. Yes, I did.
Q. And did your prescribed plan of treatment include a barium enema?
A. Correct.

Q. Why did the plan of treatment -- well, first, what is a barium?

A. A barium enema is a radiological study where contrast which is barium in this case is injected through the rectum or the anal canal or the anal opening to kind of see the anatomy of the rectum and give us idea about the length that's available in the distal -- in the remaining colon -- excuse me -- in the remaining rectum.

Q. And why would you need to know that?

A. It helps with surgical planning to kind of get an idea how much length is available distally to help with the anastomosis or hooking the colon back up.

Sometimes it also helps to identify any other abnormality like a mass or a growth.

Q. Did your prescribed plan of treatment include a colostomy reversal surgery in February of 2017?

A. Yes, I did include that as my plan of treatment.

Q. Why did you include that in the plan of treatment?

MR. CORBET: Just for the record, leading on these last couple or that earlier question. I was trying to unmute it.

BY MR. CROSS:

Q. You may answer.

A. Okay. So my standard care for anybody that gets a

colostomy is to wait for about six to eight weeks. The reason I wait for six to eight weeks is to reduce any swelling or inflammation or edema from the surgery so that the second surgery or colostomy takedown becomes easier.

The goal is to establish the natural route for the patient so that he or she can have natural route to poop and have bowel movements.

Q. Did I hear you use the term standard of care just now?

A. This is my standard practice.

Q. Okay. Are you familiar with the term standard of care?

MR. SCARBER: I'm just going to place an objection to relevancy. This isn't a malpractice case.

MR. CORBET: Join.

BY MR. CROSS:

Q. You may answer.

A. I'm sorry. I didn't get that question again. Could you repeat that?

Q. Are you familiar with the term standard of care?

A. Yes, I am.

Q. What is the standard of -- what does that term mean?

A. To me it means what I would normally do in a particular situation or a health condition.

Q. Okay. And I'm going to show you another document. Can you see the document?

A. Yes.

Q. Do you recognize what it is?

A. Yes. I think this was a letter to kind of make a request for approval for his colostomy reversal surgery.

Q. Okay. And is that your signature?

A. Yes, it is.

Q. Are you the author of this letter?

A. Yes.

Q. So you wrote: My recommendation and standard of care for this patient is to have a barium enema x-ray via the distal rectal stump and a colostomy reversal?

A. Correct.

Q. Why did you recommend a colostomy reversal?

A. Colostomy is a diversion, and for this patient, it was meant to be a temporary plan to let the infection settle, and the original plan was to kind of hook him back up. So that was the plan to do a colostomy reversal.

Q. So were you able to follow your prescribed plan of treatment for this patient?

A. I had plan for tentative surgery in February, but I was told that his surgery was not approved. So I was

not able to perform the second surgery for the patient.

Q. Was there a medical reason the patient could not have undergone the second surgery that you were aware of?

A. Not that I'm aware of. He did not have any other medical conditions that I was aware that would make him ineligible for surgery.

Q. So --

MR. CORBET: Just a relevance objection.

BY MR. CROSS:

Q. Would it be fair to say that your prescribed plan of treatment was interfered with for a nonmedical reason?

MR. CORBET: Form and foundation.

MR. SCARBER: Leading.

MR. CORBET: Join.

BY MR. CROSS:

Q. You may answer.

A. I do not know that.

Q. Do you know who was responsible for approving or not approving the colostomy reversal surgery that you planned?

A. I do not know that.

Q. Okay. Let me go back to this exhibit. This has been marked as Plaintiff's Exhibit 4.

MR. SCARBER: Ian, I don't want to

interrupt, but I got Exhibit 1, and that was her original note.

But did we go through 2 and 3 already?

MR. CROSS: No, we haven't.

MR. SCARBER: Okay. I'm sorry. All right.

MR. CROSS: I skipped to 4.

MR. SCARBER: Okay. I thought I missed something.

BY MR. CROSS:

Q. Okay. And I'm going to draw your attention to this last page here, this fax cover sheet.

Do you see it says Hope Surgical Services at the top? What is Hope Surgical Services, if you know?

A. Hope Surgical Services was the surgical group or the surgical division of Physician Healthcare Network.

Q. And this person that faxed this from, Kathy, do you know who that person is?

A. Kathy was my office manager at that time.

Q. Do you know her last name?

A. I do not remember her last name right now.

Q. Do you know any other information that would be useful if we wanted to find Kathy to identify her?

A. I would contact Physical Healthcare Network.

Q. And I see the fax is to a Colleen.

Do you know who Colleen is?

A. I do not know who Colleen is.

Q. Do you know if this fax was sent at your direction?

A. I do not remember but I believe so.

Q. Okay. Why would you direct your office manager to fax this letter and this document to a Colleen?

MR. SCARBER: Foundation, calls for speculation.

BY MR. CROSS:

Q. You may answer.

MR. CORBET: Join.

THE WITNESS: Usually the protocol is whenever we get -- in my practice when we schedule a surgery, we get an insurance authorization.

So it could be that the patient was not authorized for surgery, and I wrote this letter to make a case for the surgery and asked her to fax it over to the insurance company.

But I do not know for sure if Colleen is a part of that because it doesn't say anything, any more details.

BY MR. CROSS:

Q. Okay.

A. Can I take a break?

Q. Sure.

How long do you need?

A. About five minutes.

Q. Sure.

A. Thank you.

THE VIDEOGRAPHER: We are going off the record at 1:27 p.m.

(Off the record at 1:27 p.m.)

(Back on the record at 1:33 p.m.)

THE VIDEOGRAPHER: We are back on the record at 1:33 p.m.

BY MR. CROSS:

Q. Doctor Kansakar, I believe you testified before that you had performed at least dozens, perhaps a hundred colostomy reversal procedures in your career.

Do you currently treat patients with Medicare?

A. Yes, I do.

Q. Are you a participant in the Medicare program?

A. Currently I'm employed through CHI which is Franciscan Health, Catholic Health Initiative, and I believe I am a part of the Medicare provider, but I have to check to verify that.

Q. Have you ever performed a colostomy reversal procedure for a Medicare recipient?

A. I haven't -- I do not check that to see if it's a

Medicare or any other insurance, so I do not know the answer to that.

MR. CORBET: Relevance objection.

MR. SCARBER: Same.

BY MR. CROSS:

Q. Do you typically have issues with health insurance companies declining to cover colostomy reversal procedures?

MR. SCARBER: I'm just going to place an objection.

MR. CORBET: Same objection.

MR. SCARBER: Go ahead.

MR. CORBET: Just same objection, form and foundation.

MR. SCARBER: Same objection to relevancy.

BY MR. CROSS:

Q. You may answer.

A. I'm not aware of. I do not know.

Q. You don't know?

A. No.

Q. What are -- let me ask you this. Do you ever place an ostomy with the intention that the ostomy be permanent?

A. Yes, there are occasions where I would place an ostomy knowing that that would be a permanent ostomy.

Q. And when would you do that?
A. There are certain medical conditions where there could be tumor or cancer which is very low in the colon. It may involve the sphincter that's responsible for the continence or incontinence.
And if that is involved, then, unfortunately, it would not be an option to hook the colostomy back to any remnant there because that would lead to incontinence.
Q. I see.
A. There could be certain medical conditions like patients having very severe cardiac condition or lung condition which would make another surgery very high risk, and in those individuals, colostomy would be permanent.
Q. So barring those situations, would you typically try to reverse a colostomy at some point after you placed it?
A. Yes, that would be my recommendation to try and reverse the colostomy.
MR. CORBET: Same objection.
BY MR. CROSS:
Q. And how long would you typically wait before reversing the colostomy?
A. I typically wait between six to eight weeks from the original surgery.

Q. Would there be a medical reason that you might wait, say, five years?
MR. CORBET: Same objection.
THE WITNESS: Not to my knowledge.
MR. CROSS: Okay. I don't have further questions.
MR. CORBET: Devlin, would you like to go first or would you like me to go first?
MR. SCARBER: You go ahead and I'll follow.
EXAMINATION BY MR. CORBET:
Q. Okay. Hi, Doctor Kansakar. My name is Dan Corbet. I'm going to ask you a few follow-up questions, okay?
A. Sure.
Q. You said you remembered the name Kathy.
Was that your office manager from the Port Huron office I believe?
A. Correct. She was our office manager at Hope Surgical Services.
Q. And do you happen to remember a conversation with her that about this patient in February of 2017?
A. No. It's been long, and I really do not remember any other than what's in the medical records.
Q. And I don't blame you one bit. I wouldn't remember something four years ago, either, that specific, and

that's why we have some records.
So I'm going to see if I can try to refresh your recollection, okay?
A. Okay.
Q. Let me see if I can pull up a document here.
Doctor, can you see the note that I put up on the screen?
A. Uh-huh, yes, I can.
Q. We can call this Defendant's Exhibit 1.
And do you see the date on the left-hand side, it says February 1, 2017?
A. Okay. Yes, I do.
Q. And if we read the note, can you read it to yourself, see if it will refresh your recollection?
A. Inmate's colostomy reversal is currently pending. Per Doctor Kansakar's office manager, Kathy, the colostomy reversal is not life threatening or emergent. When Kathy was asked for a specific timeframe to have the procedure completed per recommended standard of care, she stated there is not a timeframe. It is not a life-threatening condition. It is based on personal comfort of the patient. Inmate's surgery will remain postponed at this time. Will continue to assess and monitor. Colleen Dwean.
Q. I'm sorry. Go ahead.

Okay. So does that refresh your recollection of having a conversation with Kathy back then?
A. No, it doesn't.
Q. Let me try another one.
Doctor, here's a note from the state prison, and near the bottom of it, can you read -- can you see my mouse?
A. Yes, I do.
Q. Can you read that, two sentences?
A. No urgent -- yeah. Okay. No urgent medical issues were reported from the surgeon's office, and the colostomy is functional. It is not likely that the colostomy will be reversed in the MDOC.
Q. Now, do you see the date on this one?
A. That is March 29, 2017.
Q. All right. Where it talks about no urgent medical issues were reported from the surgeon's office and the colostomy is functional, do you happen to have a recollection of maybe talking to either your office manager or somebody about the patient back on or about March 29, 2017?
A. No. When I reviewed the medical records, I think the last office note was 1-10, and, unfortunately, I do not have any other, you know, recollection of the

details.
Q. Okay. So we'll call this one for the record Defendants' Exhibit 2. Yeah, 2.
So, Doctor, let me try to refresh your recollection with one more note. Doctor, let me get the date of this thing. So here's another note from the state prison.
Can you read the date of that for us?
A. It's 4-7, 2017.
Q. Okay. And the only place it mentions surgeon is -- can you see where my mouse is and start reading there, just that sentence?
A. No medical necessity per outside documentation or from conversation with surgeon's office, Doctor Kansakar.
Q. So does this refresh your recollection that maybe you had a conversation with somebody either from the state prison or in your office?
A. Unfortunately, I do not.
Q. Okay. Nobody expects you to. This is four years ago.
So if Kathy had come to you either in February, March, or April and asked you is the reversal of the colostomy medically necessary, would it be correct to say that you may have told her it's not medically necessary, it's more for the preference

of the patient, is that fair?
A. I cannot say that for sure because in my mind, you know, I want the natural route to be established for the patient.
Q. Certainly.
But if you were asked is this more for the preference of the patient or is this a medically necessary procedure, would it be your custom, habit, and procedure if you were asked that question at that time that you may have said, yes, it is more for the preference of the patient than required as a medical necessity?
MR. CROSS: Objection, calls for speculation.
BY MR. CORBET:
Q. Do you remember the question, Doctor?
A. Could you repeat that again?
Q. Sure. If you had talked to somebody in your office, possibly Kathy, in January -- I'm sorry -- in February, March, or April of 2017 and she told you that the jail or the prison had called and wanted to know if this is a medically necessary procedure to reverse the colostomy, is it possible you may have said, well, it's more for the preference of the patient, it's not technically a medically necessary

procedure. Based on your custom, habit, and practice, would you have said something along those lines to Kathy?
A. I do not know that. Usually my answer would be it's a lifestyle-altering procedure for the patient, and it's -- it would be very normal for the patient to have a natural route established.
I would recommend colostomy reversal. The timeframe is usually after the initial six to eight weeks' window. It's not, it's not definite, like, when I would do it, but, you know, I would prefer to do it within, within some reasonable time as long as the initial six to eight weeks is over, and it could depend upon, you know, surgeon's availability or operating room availability and patient's time preference.
Q. If Kathy had told these -- the persons that called from either the jail and/or the prison, had told them that it was a preference as opposed to a medical necessity, would she have been in error doing that?
A. I do not know if she said that, so I cannot answer that question.
Q. Well, I'm allowed to ask you hypotheticals, and I'm going based on these notes in the chart here, and I showed you three notes.

If Kathy had actually said something along those lines that it's not medically necessary according to Doctor Kansakar, it's more of a lifestyle preference, are you saying she was in error telling that to the jail person?
A. No, it's not a life-threatening situation. As I said, it's more of a quality of life.
Q. Okay. And the term I used was medically necessary I think at one point in time because I think I saw that in one of the notes, so let me use that term again.
If Kathy had told someone from the jail or someone from the prison that the reversal of the colostomy was a lifestyle preference as opposed to medically necessary, would Kathy have told us -- told them something that was incorrect?
A. I -- again, it's when you say about medical necessity, it also depends upon, like, the psychological well-being of a person.
So if I was a, if I was a patient, I was, you know, I believe he was thirty-four or thirty-five at that time, and I did not have any other medical conditions which would prohibit me from getting a surgery, I would like to have my normal anatomy established so that, you know, I don't have to have a bag which can potentially leak and cause a problem

and, you know, potential embarrassment.

So I would say if you consider the medical well-being of the person both, like, for psychological well-being, for being -- feeling well in general, I think having a colostomy reversal would be much more preferred than having a colostomy.

MR. CORBET: For the record, motion to strike as being way over what I asked.

BY MR. CORBET:

Q. Doctor, my question was a little bit shorter and simpler. If Kathy had told somebody from the jail who called or somebody from the prison who called that the reversal of the colostomy was a lifestyle preference as opposed to a medical necessary procedure, would she have been incorrect to tell them that?

MR. CROSS: Objection, asked and answered.

But you can answer.

THE WITNESS: Well, I do not, I do not know that answer, you know. Yes, as I said, it's something that would be -- it's not a life-threatening condition.

If she had said that, again, it's a hypothetical scenario, and I would prefer not to answer hypothetical questions, especially when I wasn't the one who gave that answer.

BY MR. CORBET:

Q. Right, but we're allowed to ask you hypothetical questions, and we'll get a chance to ask Kathy questions and try to connect the dots.

But at this moment, I still need to ask you that question. Would that have been something incorrect for Kathy to have told the jail or prison or whoever called and talked to her that the reversal was not medically necessary but it is a lifestyle preference?

A. I think I would say it is medically necessary to have the colostomy reversed for the general well-being of the patient.

Q. And is there a time limit on when you think that -- strike that.

MR. CORBET: I'm going to move to strike that answer.

BY MR. CROSS:

Q. Would Doctor -- Doctor, would Kathy have been incorrect, though, if she told that to the jail person?

MR. CROSS: Objection, asked and answered.

BY MR. CORBET:

Q. You can answer the question. Would Kathy have been incorrect to tell that to the jail person that this was not medically necessary, it was a lifestyle preference?

A. I think I would agree with the first part which says it's not medically necessary, but I do not agree with just the second part that it's just a lifestyle preference. It's for the mental and, you know, psychological well-being to have a normal colostomy, I mean colostomy reversed and having a natural route reestablished.

MR. CORBET: Okay. Thank you. That's all I have.

EXAMINATION BY MR. SCARBER:

Q. Good afternoon again, Doctor Kansakar. Devlin Scarber appearing on behalf of the Corizon defendants, the individuals at the -- who provided health care at the Michigan Department of Corrections prison.

A. Good afternoon.

Q. I think I mentioned during our break, if you'd be kind enough to provide Mr. Oswald with a copy of your CV, I guess what we also call a resume, that would be great, and he can get that over to us probably shortly after you provide it to him, and that will give us a little bit more information about your background.

A. That would not be a problem.

Q. Okay. So thank you. I sure would appreciate that.

I'm just going to follow up on the last couple of exhibits that the plaintiff -- I'm sorry -- that Mr. Corbet asked you about with respect to those documentations from Kathy who was -- who you indicated was your office manager. And we discussed the fact that it's -- it was over -- it was four years ago when these conversations or notes took place.

Is it fair to say that you're not saying those conversations didn't happen; you're just saying that you can't recall that at this point because now it's four years later?

A. I agree.

Q. Okay.

A. It's been four years, and I do not have the recollection of all the conversations I've had.

Q. So it could have happened, it couldn't have happened, you just don't remember at this point, right?

A. Yes, sir.

Q. Okay. And with respect to the documentation that was, that was done by the jail health care staff as well as the prison health care staff, they got documentation about a conversation that took place.

And as far as you know, you don't have any documentation about that, correct?

A. Yeah. The last -- this is the first time when it was

shown here at the exhibit that I have seen those two documents.

Q. Right.

A. The only communication that I had from my side is the note that was a typewritten note on Hope Surgical letterhead from January 24th, and that's all I have in writing as my reference.

Q. Okay. So the answer to my question would probably be correct then. It's fair to say that you have no documentation regarding anything that would dispute you having such conversations or your office having conversations with the jail on January or -- I'm sorry -- February 1st of 2017 and again with the prison health care professionals on March 29, on or around March 29th, 2017, or April 7th, 2017, correct?

A. Correct.

Q. Now, when you performed your original surgery on Mr. Jackson back in December of 2016, would you consider that that surgery was medically emergent, it was absolutely necessary that you had to perform that surgery immediately for his well-being?

A. Yes. I agree that he needed that surgery sooner than later.

Q. And he needed it as soon as possible, correct?

A. Yes, because he was having -- from what I understand,

he had a communication or a fistula between his colon and the bladder, as a result of which the stool was leaking into the bladder, and he was having urinary tract infection.

Q. And when you performed that particular procedure on him on December 10th of 2016, there were risks associated with that procedure, right, even though it was an emergency kind of situation or a medically necessary kind of situation, right?

A. Could you repeat that question, please?

Q. When you performed that colostomy surgery that you performed on him back in December 10th of 2016, there were risks and complications that could have resulted from that surgery even though he needed it. There were risks that were facing him potentially, correct?

A. Correct.

Q. And you advised him of those risks, correct?

A. I think that was -- that would be part of my discussion with him.

Q. Okay. Let me move around a little bit here, Doctor. I apologize. If there's a delay on my end, it's because I'm trying to use my screen that's not necessarily connected to my computer. I'm on a cloud, so give me a minute. If there are any delays, I apologize in advance here because I've got to do

scrolling.

MR. CORBET: Devlin, is any of the records I had up there do you want me to pop up for you?

MR. SCARBER: No, no. I've got some other stuff.

MR. CORBET: All right. No problem.

MR. SCARBER: And I'm getting it together. I think once I get rolling, I'll be good.

BY MR. SCARBER:

Q. Doctor, are you able to see this note on the screen?

A. Yes, I do.

Q. Okay. And this is explaining the risk of anesthesia.

Now, I understand you performed -- what was that surgery you performed on him on December the 10th of 2016? What was the name of that?

A. It's called a sigmoid colectomy.

Q. Okay. And there are risks associated with that particular procedure, correct?

A. Correct.

Q. And I've just highlighted one of the risks, and one of the risks is anesthesia, correct?

A. Correct.

Q. And are you able to see this on your screen again?

A. Yes.

Q. Okay. And I think it indicates here that some of

those complications with anesthesia are possibility of infection, bleeding, drug reaction, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack, and death.

Did I just read those correctly?

A. Yes.

Q. And those are the things that are explained to the patient before he has a procedure like that, right?

A. Correct.

Q. And that's just with anesthesia, but there's also risks just associated with the surgery, period, and here it indicates that -- are you able to see my screen?

A. Yes, sir.

Q. Here it indicates that these operations and procedures carry the risk of unsuccessful results, complications, injury, or even death.

That's correct, right?

A. Yes, sir.

Q. And those are possibilities that can happen with these surgeries, correct?

A. Yes, sir.

Q. And, in fact, you're so concerned about those particular type of things occurring that you actually have the patient sign an informed consent indicating

that he's aware that those things could happen, right?
A. Yes.
Q. Give me one second here. In a perfect world, I would have just photocopied each page and just had it simpler so I didn't have to do all this scrolling.
I think I'm on your operative report, but I want to go to a specific page here.
Now, this is from your operative report in December of 2016, and can you see what I've kind of highlighted right there?
A. Yes, sir.
Q. And it indicates that even in your -- not just the hospital forms that the patient signed but it also appears that even in your operative report, you double document that you explained the risks and dangers associated with the procedure that you performed, correct?
A. Yes, sir.
Q. And you indicate here that the risks and potential complications could be bleeding, infection, inadvertent urethral injury. Patient elected to undergo an open sigmoid colectomy but not before you put in here what the risk could be, right?
A. I'm sorry. Could you explain -- restate the question?
Q. Yeah. You explained these risks to him, correct?

A. Yes, I did.
Q. All right. And before you would perform this surgery, he had to understand these risks and be aware that these things could happen, correct?
A. Yes. That would be part of my practice to explain that to my patients.
Q. And you're not just making this stuff up, right? Something has told you that these things can happen, and that's why you're informing them, right?
A. Yes, sir.
Q. Now, I understand that you indicated that you had a plan to -- you had established a plan of care for Mr. Jackson, and I understand that that was based upon certain things that you wanted to do, particularly in your practice, correct?
A. Yes, that's correct.
Q. As per what your practice is, right?
A. Correct.
Q. Not anybody else's practice but per what your practice is, right?
A. I do not know about other's practice, but that's how I was trained to wait for about six to eight weeks to minimize any swelling and infection and then put the patient or put the colostomy back together.
Q. And I'm just going back to your testimony as well as

your letter, and your testimony was very clear when we started this deposition that it's your practice to do that. Your letter even said my practice or my standard is to do that.
You're talking about -- what you're talking about is what you do, correct, not necessarily what everybody else does, right?
A. Yes, sir.
Q. Okay.
MR. CROSS: Objection, mischaracterizes the exhibit.
BY MR. SCARBER:
Q. And, in fact, when you -- I've got to ask you, do you have a chart in front of you?
A. Patient's chart, yes, the medical records.
Q. Okay. And what exactly do you have in front of you? Is that something that you got from the medical office, or what do you have in front of you?
A. So I have my office notes, the operative report, and I have a letter that was written on the Hope Surgical Services letterhead dated January 24th and then a handwritten note dated 12-27.
Q. Okay. So let's go to your -- do you have your records from your post-op records where you treated Mr. Jackson?

A. Yes, I have access to my post-op records when I saw him after surgery.
Q. Okay. So the first time you saw Mr. Jackson after surgery, would that have been December 27th, 2016?
A. Let me check real quick.
Yes, December 27, 2016.
Q. Okay. Is this your record here?
A. Yes.
Q. Okay. This should be -- this is probably what you have in front of you.
I know we've got three attorneys here, and I think we've all gotten records, and some of them might -- I think they all say the same thing on them, but maybe they've got a line or two here that's different or one line is on page five instead of page six. I don't know how they print them out, but I think we've got the same documents here.
So this is your December 27th visit in 2016.
A. Uh-huh. Yes, sir.
Q. And you note that his ostomy is pink and productive, right?
A. Correct.
Q. And I seem to remember that they talked about -- this is based upon prior, prior experience I've got with

colostomies, but there's, like, three Ps in ostomy care, right? Have you ever heard that?

A. The three Ps? I'm not quite sure, sir.

Q. Pink, patent, and productive.

A. Okay. Yes.

Q. It doesn't matter. If you haven't heard of it, you haven't heard of it.

But you say it's pink and productive, right?

A. Correct.

Q. And it's got no problems and no problems with functioning, right?

A. Not according to my note.

Q. And you've got written in here no new complaints, right?

A. Correct.

Q. That means the patient wasn't complaining to you about anything, right?

A. No new complaints at that point, correct.

Q. All right. Functional colostomy, correct?

A. Correct.

Q. You see him again on 1-10, January 10, 2017, right?

A. Yes, that was my office note from January 10, 2017.

Q. When you see him on January 10th, 2017, his colostomy was functioning fine, right?

A. Yeah. It says colostomy was pink and productive.

Q. Even -- he was even -- even when you did a, you did a physical examination on him, he was able to stand and walk properly, correct?

A. Yes, I believe so. It doesn't -- as per my note, there was nothing that says he wasn't able to walk.

Q. And at that point he was not having any issues that you recorded in your report, correct?

A. Correct. As per my note, you know, pain was well controlled, and some drainage was noted from the incision.

Q. Is there anything indicating here that his colostomy was not functional?

A. No, sir.

Q. All right. In fact, you said it was, right?

A. Correct.

Q. Is there anything in here, Doctor, where you have anything noted about this particular patient complaining about he wants a reversal or he absolutely has to have a reversal and he's discussing that with you and discussing anything in detail about how this is affecting him and all that kind of stuff? I didn't see anything, but you tell me. Is there anything in here?

A. Not that I can see.

Q. You certainly didn't document anything like that, right?

A. Correct. Again, I did not document that.

Q. And that, I mean, concerns that are important that you get from a patient you document, right?

A. Yes.

Q. Okay. And this was the last visit that you actually saw Mr. Jackson, January 10th, 2017, correct?

A. Yeah. That's the last note I have from the medical records, so I believe that's the last time I saw him.

Q. And I know you had indicated a plan, you know, your plan that you wanted to do or were anticipating doing a reversal, but I didn't see any note where you specifically explained anything about a reversal to Mr. Jackson.

A. I think there was a handwritten note from December 7 -- excuse me -- December 27th which laid out a plan for surgery. It's a handwritten note on my office letterhead. That was part of my -- of the medical records that was given to me.

Q. Did you discuss anything with him on January 10th, the next time you saw him?

A. I do not know that, sir, because it's not in my medical records, and I do not remember what happened on that day.

Q. Okay. And the note you're referencing from December 27th on your letterhead, is that a discussion you had with Mr. Jackson, or is that just some notes that you had written down about a potential plan?

A. No. This is what I discussed with the patient I believe. This is, you know, this is a documentation. So I'm very much sure that I discussed this with the patient.

Q. But nothing on January 10th, the last time you saw him?

A. Yeah. I don't see any, like, repetition of those reports. I do see that, you know, there's a colostomy reversal planned for February 9th.

Q. Okay. This, this colostomy reversal plan for February 9th of 2017, was that a date? Who picked that date? How did that date even come about, do you know?

A. The index surgery or the first surgery was on 12-10 I believe, and, again, after the surgery is done, I wait about six to eight weeks to let all the infection, the inflammation, swelling, scarring to settle down.

So eight weeks from that would put us in February, and that's how I chose that tentative date to -- depending upon my schedule, the OR availability to choose a date.

Q. Okay. I got it. I think I understand this.

So this date you put in here was really just some calculation that you had from the time you had done the original surgery, right?

A. So, yes. Again, I would generally wait for six to eight weeks after this kind of surgery to start to do the second surgery because trying to go any time earlier than that would cause a lot of swelling and potentially more harm than or injury because of the, you know, the adhesions or scar tissues.

So six to eight weeks' time, make sure that the scars are not as bad, and second surgery is going to be done more easier.

Q. Right.

And I think I'm just asking you, though, and you might have answered it, but just my simple question is this date is a date it sounds like that you just selected based upon your calculation of when he would heal and when you thought he could do a surgery, right?

A. Correct.

Q. Okay. You never spoke with the individual health care professionals at the Michigan Department of Corrections about this or Corizon or any of the health care professions there, correct?

A. I do not recall.

Q. Well, let me just tell you this. He wasn't even in prison at that time in February 9th, 2017. He wasn't even there yet, so you obviously didn't discuss this with them, correct?

A. I don't think so, sir, but I do not have any notes to refer to that. So I do not know the answer to that. I don't recall any conversations.

Q. So assuming that he doesn't even get to the Michigan Department of Corrections until March, late March of 2017, then you would agree that this was never a plan that you communicated to the health care professionals at the prison, right, assuming that he wasn't even there yet, correct?

A. I do not know, like, how, how or where he was housed during this time, you know.

I kind of laid out my plan as per the medical records, you know. Everything that I did is in the medical records, and, you know, the plan was to do a colostomy reversal with a tentative date of February 9th.

Q. Doctor, I don't want to interrupt you, but I think you might have almost answered my question but not quite answered it, and I don't want to cut you off because I think I got the response to the end of your answer there already.

But my question is assuming that Mr. Jackson was not even in prison in February of 2017, then this particular date that you came up with in December or January is obviously not something that you could have discussed with him because he wasn't even there yet.

You would agree with that, right?

A. I'm sorry. I don't think I understand the hypothetical situation.

Q. The hypothetical is you apparently wrote a note in your record indicating a reversal for February 9th of 2017.

Now, if Mr. Jackson was not even in prison until after March of 2017, then you would agree that you never discussed the February 9th, 2017, date with the prison? It's just a simple question.

A. Yeah. If he wasn't in the prison, then I guess, like, I wouldn't have discussed that.

Q. Okay.

A. It could be any other, like, a patient who would come to my office, and I would discuss the plan with the patient.

Q. Okay. Now, we know that Mr. Jackson ultimately underwent a reversal surgery on June 9th, June 19th of 2019.

My question for you is did you ever discuss any of the risks and complications that could arise from a reversal surgery with Mr. Jackson?

A. I believe I did, but, again, I'll have to refer to my notes, and I do not recall, like, anything in particular.

Q. Do your notes indicate that just like your prior notes from the hospital where you were telling him, you know, that you were going to proceed with the surgery and you discussed the risks, benefits, and complications of the procedure for the procedure that occurred in December.

Do your notes in any way from the Hope Surgical Services or anyplace you saw him as far as you know indicate that you had such discussions with him for a potential reversal surgery in February of 2017?

A. Yes, there is a date mentioned that there is, you know, that's the tentative date for surgery, and I believe it mentions in my operative report that I had the discussion, but I may not have documented that in my office note.

Q. Well, let me -- my question might have been confusing. You never got to the -- there was never a reversal surgery done by you in February, so there is no

operative report regarding that.

What I want to know is if any of your office notes where you saw him specifically discuss the risks and complications that could arise from a reversal surgery.

A. There's no documentation that I can see in my notes.

Q. And if you were -- when you get ready to perform a surgery, you actually do document that in your notes, right? Because I saw one in the December 2016 notes.

A. Yes, but, yes, that's true, I would have documented, but probably it could be that I was waiting or anticipating another meeting, office meeting with him just, like, closer to the surgery date to kind of go over the instructions again, to explain everything in detail. So that could have been a potential plan.

Q. Right.

So I guess what I'm saying is although you had planned to do a surgery, you didn't really complete all of the normal protocols that you would have actually done in order to actually definitively say that that surgery was going to happen, correct?

A. Well, I had plan for sure. I had, you know, surgical date chosen. So I would say I had, like, a plan for colostomy reversal.

I had -- as per my note, I had mentioned

that he needs antibiotics one day before surgery. I had, you know, plan for him to drink the prep for the colostomy reversal at 7:00 a.m. the day before surgery. I had instructed him to use, like, bath scrubs, special soap scrub. So I was kind of -- I had done my part in terms of preparing for the second surgery.

Q. But you hadn't gotten around to doing all of the things that you would normally do if you were going to perform a surgery, correct?

For instance, we don't have any documentation of you actually discussing the risks and complications and benefits of the procedure like we have in your previous records, and you also wanted a barium enema to be done.

So you were still waiting on tests, correct?

A. Yes. I was still waiting for the workup to be completed at that time, yes.

Q. Right.

And it hadn't been completed as of February of 2019 as far as you know, correct?

A. Well, from what I --

Q. Doctor, my question is -- let me strike that. My question's bad.

MR. CROSS: Let her answer the question.

MR. SCARBER: But it was an improper question, and that's why she's having trouble answering.

BY MR. SCARBER:

Q. What I should say is as of January 10th, 2017, when you last saw him, there was still things you were waiting on in terms of the final workup before you actually would have performed the surgery, correct?

A. Yes.

Q. Okay. And it's my understanding that with reversal surgeries, there is also significant risk, right, with colostomy reversal surgeries?

A. Yes.

Q. And, in fact, when he had his surgery done in June of 2019, it looks like some of that stuff is discussed. Here's the operative report from the doctor who performed the reversal surgery, and I have highlighted here, it says: The patient was made aware of risks and benefits of the procedure, including but not limited to the risk of heart attack, stroke, death, infection, the potential need for reoperation and the potential for a leak or potential for damage to surrounding structures including the ureter and genitourinary system. I probably pronounced that word

wrong.

But do you see that?

A. Yes, sir.

Q. And these are real things that can occur, correct?

A. Yes, sir.

Q. And that's why the doctors explain these things to the patient before they perform these procedures, right, so that they're aware that these are things and complications and risks that can occur, right?

A. Yes, sir.

Q. Now, it also notes in this record, it indicates that the doctor is recognizing the fact that you performed a procedure on him on December 10th, 2016, your exploratory laparotomy with sigmoid colectomy and Hartmann's procedure. It indicates that the urologist also fixed his urinary bladder.

And it says here, can you read that for me?

A. He now has no issues.

Q. All right. And he didn't have any issues when you saw him last on January 10th, 2017, with respect to the functioning of his colostomy, correct?

A. Yes, sir.

Q. Am I correct in that?

A. Yes, sir, you are correct.

Q. And he didn't have any issues on June --

A. I'm sorry. I didn't get that last part.
Q. And he also didn't have any issues, at least according to the surgeon, on June 19th, 2019, right?
A. As per --

MR. OSWALD: Objection with respect to it's calling Doctor Kansakar to testify regarding another doctor's note. She didn't treat.
MR. SCARBER: Okay. No speaking objections.
What's your objection?
MR. OSWALD: That it's not within her knowledge of what the note was at that time.
MR. SCARBER: So calls for speculation and foundation. I got it.
BY MR. SCARBER:
Q. Per this note, this note is dated surgery as June 19th, 2019, correct?
A. Yes, sir.
Q. And in this particular note, I just read it to you, it's highlighted here, he has no issues, correct?
A. Yes, it's written as he has no issues.
Q. Okay. Now, we talked about complications and medical risks associated with surgeries, particularly your first colostomy -- I'm sorry -- your initial colostomy

surgery as well as a reversal surgery.
I want to take you to a document that was filed with the court by the plaintiffs in this particular case, and this is a document called UpToDate.
And you're familiar with UpToDate?
A. Yes, I am.
Q. And this document was filed as ECF number 12-6, page ID 227.
And it indicates -- can you read this to yourself here, what's highlighted?
A. Subsequent closure of the colostomy is a technically difficult operation associated with higher -- this is kind of hidden here.
Could you move the screen? It's kind of hidden behind the --
Q. Oh, I'm sorry.
MR. CORBET: You might want to scroll down so it will be at the bottom margin.
THE WITNESS: I'm just going to move my screen a little bit.
BY MR. SCARBER:
Q. Are you having difficulty reading it?
A. The videos are kind of blocking the text.
Q. How about, how about there, better?

A. Thank you.
Q. Okay.
A. It says: Subsequent closure of the colostomy is a technically difficult operation associated with high morbidity and mortality rates. As a result, colostomy closure is only performed in approximately fifty to sixty percent of all patients after a Hartmann procedure.
Q. And you did a Hartmann's procedure, correct?
A. Yes, sir, I did.
Q. And how about this one that I'm going to show you here, starting here.
A. In a retrospective administrative database study of sixteen sixty patients who underwent Hartmann procedure for diverticulitis, only twenty-eight point three percent underwent colostomy reversal within a year. Outcomes of the reversal surgery were not influenced by the time lapse from the index operation. The optimal timing of colostomy reversal remains undefined and at the discretion of the surgeon.
Q. Now, you don't disagree with that medical literature, do you?
A. No, I do not disagree, but, again, it's quoted only one study, so I do not know if that's, like, that's the -- I'm sure there are other studies kind of giving

more information. So it looks like one study there, and it references --
Q. It actually quotes about three studies.
A. I see.
Q. Each one of these items here is a particular study. Let me go down. So we've got 21, 22, 23, and 24. Hang on a minute. Let me see if I can go down it.
Well, let me just ask you this to save some time here. What this basically says, these different studies that it's talking about, is basically saying that there can be differences of opinion, differences of opinions amongst doctors regarding colostomy reversal, right, whether we do it, the timing of when it can be done, things like that, correct?
A. Yes, sir.
Q. And you don't disagree with that, right?
A. No, I do not disagree with that.
Q. Okay.
A. Could I take another break?
Q. Yes.
A. Thank you. For five minutes, please?
THE VIDEOGRAPHER: We're going off the record at 2:35 p.m.
(Off the record at 2:35 p.m.)
(Back on the record at 2:44 p.m.)

THE VIDEOGRAPHER: We are back on the record at 2:44 p.m.
BY MR. SCARBER:
Q. Doctor, just to follow up with you regarding what we were talking about when we last left off, here are some of those articles that were filed or that were referenced in a court filing.
Are you able to see my screen?
A. Yes, sir.
Q. Okay. One of the articles being What Proportion of Patients with an Ostomy for Diverticulitis Get Reversed, another one being Restoration of Bowel Continuity After Surgery for Acute Perforated Diverticulitis: Should Hartmann's Procedure be Considered a One-Stage Procedure, Feasibility and Morbidity of Reversal of Hartmann's, so Avoiding or Reversing Hartmann's Procedures.
So there's a number of articles that would seem to indicate that it's certainly within a particular medical provider's medical judgment as to what they are going to do or what they think is appropriate for a particular patient, correct?
A. Correct, sir.
Q. And you don't disagree with that, right?
A. I do not disagree with that.

Q. When you're going to do a reversal, essentially what you're trying to do is alter or adjust the patient's body or their body structure, right, back to what it was, correct?
A. Yes, sir.
Q. I mean, you're trying to put a patient back in some kind of original way, correct?
A. Correct. The goal is to establish the natural continuity.
Q. And it's reconstructive in the sense that you're trying to reform the body structure back to how it was previously in terms of what you indicated in terms of how to have their waste excreted in the original way, correct?
A. Yes, sir.
MR. SCARBER: Doctor Kansakar, I don't think I have anything further. I want to thank you for your time.
THE WITNESS: Thank you, sir.
MR. CROSS: I have a little bit of redirect.
REEXAMINATION BY MR. CROSS:
Q. Doctor Kansakar, I believe you --
MR. CORBET: Is anybody else there, Ian? I thought we ought to identify everybody in the room.

MR. CROSS: Yes. Larry Margolis is here.
MR. MARGOLIS: Good afternoon, people. I identified myself with the court reporter. I apologize if I didn't let you know. Mr. Margolis, Larry Margolis.
BY MR. CROSS:
Q. Doctor Kansakar, I believe you testified about some risks that are associated with the procedure to place the ostomy, is that correct?
A. Could you, could you reframe the question again?
Q. Are there risks associated with the Hartmann's procedure?
A. Yes, there are.
Q. Are there risks associated with a colostomy takedown?
A. Yes, there are.
Q. Are there risks associated with every surgical procedure that involves general anesthesia?
A. Yes, there are.
Q. Do you recommend a surgery when you believe the risks of the surgery outweigh the benefits to the patient?
A. No, I do not.
MR. SCARBER: I'm just going to place an objection to relevance and foundation.
BY MR. CROSS:
Q. I believe you testified before that you performed

perhaps a hundred ostomy placements in your career?
A. That's a rough estimate. I do not know the exact number.
Q. And did you testify that Mr. Jackson was thirty-four years old at the time you placed his ostomy?
A. I believe as per his date of birth which is 2-5, 1982, he would have been thirty-four years old at that time.
Q. And I believe you testified he had no other medical complications that would make reversal especially difficult or contraindicated, is that correct?
MR. SCARBER: I'm just going to place an objection to asked and answered and leading.
BY MR. CROSS:
Q. You may answer.
A. The patient did not have any other medical comorbidities that would make him high risk for colostomy reversal.
Q. Do many of the patients you have placed an ostomy in have comorbidities?
A. Some patients do have comorbidities.
I'm sorry. Sorry about that.
Q. How does Mr. Jackson's age compare to the ages of most of the patients you perform this procedure on?
MR. SCARBER: I'm just going to place an objection now to outside, completely outside the scope

of my redirect, my direct or my redirect as well as Mr. Corbet's.

MR. CORBET: Join.

BY MR. CROSS:

Q. Go ahead.

A. So generally diverticulitis is a condition in older age group, usually sixty or higher age group. He is a younger individual getting this condition at age thirty-four.

Q. So would it be fair to say that most of the individuals you placed an ostomy in are older and sicker than Mr. Jackson?

A. Yes.

MR. SCARBER: Foundation.

BY MR. CROSS:

Q. Okay. Go ahead.

A. Sorry. So generally they are older patients than Mr. Jackson, not necessarily always sicker.

Q. Okay. And is it more difficult to reverse a colostomy in an older patient typically?

A. I do not think technically it is a difficult procedure to reverse the ostomy in an older individual.

However, in an older individual, they do have -- they do tend to have more medical comorbidities like a heart condition or a lung

condition which can be challenging for the postoperative or intraoperative care.

Q. And does that render the procedure higher risk?

A. Yes, it can be a higher risk to perform based upon other medical comorbidities of the patient.

MR. CROSS: Okay. I don't have further questions. Thank you for your time, Doctor Kansakar.

THE WITNESS: Thank you, sir.

REEXAMINATION BY MR. CORBET:

Q. Doctor, I just have a little bit of follow-up. This is Dan Corbet again. Just some housekeeping.

I don't know if I identified the April 7th jail note as an exhibit, but if I didn't, it's Defendants' Exhibit 3.

And then just, Doctor, you don't have any personal recollection of talking to the jail nurse, Colleen, or any other jail or prison personnel about reversing the colostomy, do you?

A. I do not have any recollection of talking to any other individual in person. I am just referring to my medical notes at this time.

Q. Right.

And I didn't see any notes that you personally talked to anybody at the jail regarding reversing the -- the jail or the prison regarding

reversing the colostomy, is that fair?

A. I do not see any note in person, but, again, this letter says to whom it may concern. I'm not sure where it was faxed to. From what was shown earlier, it was faxed to Colleen, but that's about it.

Q. Okay. And did you participate -- well, strike that.

I showed you several notes from the jail and prison about where it was noted that discussions were held with your office -- in one particular case, Kathy -- about reversing the colostomy.

Do you remember me showing you those notes?

A. Yes, sir.

Q. Okay. You don't know if Kathy told the jail or the prison nurses or personnel that this was medically necessary or not, do you?

A. I do not know that. From what I recall and referring back to my notes, you know, the letter states that, you know, this is what I would recommend for him, and Kathy at that time being my office manager would have taken the lead on the communication part.

Q. Right.

And the letter that you're talking about, that's dated January 24th, correct?

A. Yes, sir.

Q. And the conversation that I talked -- that I showed

you in the jail note is dated February 1, about a week later, a little more than a week later, correct?

A. Yes. I believe that was the date, but I currently don't have access to that note.

Q. Okay. You can take my word for it. Exhibit -- defendants' exhibit does show that it's February 1, 2017. But nowhere in that note -- well, strike that.

That note suggests that someone at the jail -- namely, Nurse Colleen -- spoke with your office manager, Kathy, correct?

A. Yes.

MR. CORBET: Thank you. That's all I have.

THE WITNESS: Thank you.

REEXAMINATION BY MR. SCARBER:

Q. Doctor Kansakar, just a couple follow-up questions.

First question. When you were advising Mr. Jackson about the risks and potential complications of these procedures, you didn't tell him you're young, so these things aren't going to happen to you, did you?

A. I'm sorry. These things refer to --

Q. I'm sorry. When you were -- let me rephrase my question, and let me be a little more specific. That's my fault.

When you were discussing the risks and

potential complications of this procedure with Mr. Jackson, you didn't tell him, oh, by the way, you're young, so you don't have a risk of infection, you don't have a risk for potential need for reoperation, you don't have a risk for potential leakage or damage to the surrounding structures including the ureter. You didn't tell him that he was at any less risk than anybody else, did you?

A. No, I did not tell him that he was at any risk. I don't think that would -- at least in my note, I don't mention that, and I do not recollect.

Q. Right.

And I think you said any risk, but you didn't tell him that he was at any less of a risk than any other person, did you?

A. Again, that's -- that depends upon every patient and their risk factors. It would be hard to compare him against an eighty-year-old with a lot of other comorbidities. So I don't know if this is less in terms of somebody who is eighty versus somebody who is fifty.

Again, looking at his history, he did not have any other medical comorbidities, so I would assume the risks would be less, but, again, there could still be complications like bleeding which is

not an age-related factor or age-related complication.

Q. And I think you might have answered my question, but let me just ask it in a more defined way.

When you were explaining to him the risks and complications of this potential procedure, you didn't tell him when you were explaining this stuff to him that you're only thirty-four years old or you're only -- you're just over thirty, so don't worry about it. You told him these risks because these risks can happen, correct?

A. I don't believe I told him that just because of his age factor.

The surgery itself has potential risks, and that's true with any surgery.

Q. Okay. So you didn't give him any kind of special, special risks and complications. You told him the same risks and complications that can occur with everybody, right?

A. Yes, sir.

Q. Do you see this note here?

A. Retrograde cystogram, yeah.

Q. Is this the handwritten note you were referring to?

A. No, sir.

Q. Is there a page number at the bottom of the note you're referring to?

A. I think it's page number 91.

Q. Can you hold it up to your camera because I think we've all got different notes here.

All right. Let's take a quick break, and I'll wrap this up. I don't want to waste your time while I'm looking at it on my computer, so let's just take a pause for the cause for a second.

THE VIDEOGRAPHER: We're going off the record at 3:00 p.m.

(Off the record at 3:00 p.m.)

(Back on the record at 3:03 p.m.)

THE VIDEOGRAPHER: We are back on the record at 3:03 p.m.

MR. SCARBER: Doctor Kansakar, thank you for your time again. I don't have anything further at this time.

I would note that we do reserve the right to call you later in the case if we need to for a discovery deposition as we are just at the early stages of discovery in this case.

THE WITNESS: Yes.

MR. CORBET: I'm sorry. Thank you, Doctor. I would join in that request or statement. Thank you.

MR. SCARBER: And just for my housekeeping, I tried to reference the records. I think some of us

might have the same set of records, so, Ian, we'll have to figure out I guess if we're going to be using the same set, same page numbers and all that kind of stuff.

But the records I referenced I tried to identify and I think I did on the record, so, but if I need to go back and fix that, you know, I will. But hopefully everything is identified properly in the transcript.

MR. CROSS: Sure, no problem.

I don't have any further questions, either. Thank you for your time, Doctor Kansakar.

THE WITNESS: Thank you, everybody.

THE VIDEOGRAPHER: This concludes today's deposition. We are off the record at 3:05 p.m.

(Deposition concluded at 3:05 p.m.)

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STATE OF MICHIGAN)
)SS.
COUNTY OF LIVINGSTON)

CERTIFICATE OF NOTARY PUBLIC

I certify that this transcript is a complete, true, and correct record of the testimony of the deponent to the best of my ability taken on Friday, March 5, 2021.

I also certify that prior to taking this deposition, the witness was duly remotely remotely sworn by me to tell the truth.

I also certify that I am not a relative or employee of a party, or a relative or employee of an attorney for a party, have a contract with a party, or am financially interested in the action.

Cheryl McDowell, CSR-2662
Notary Public, Livingston County
State of Michigan
Commission Expires September 13, 2025

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